MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, October 18, 2001
10:05 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

Agenda item:
What next for Medicare+Choice?
Scott Harrison

DR. HARRISON: Good morning. Today I'll give you a quick update on recent Medicare+Choice plan withdrawals and the resulting availability of plans. Then I will present a brief outline of a paper that will discuss some options for the future direction of Medicare+Choice payment policy.

I would like the Commission to discuss the outline and to provide guidance on which options should be included, and maybe even include some additional options.

The pie chart here illustrates how plan withdrawals at the end of the year will affect enrollees next year. Currently, there are 180 Medicare+Choice contracts that enroll about 5.5 million beneficiaries, which is about 14 percent of all Medicare beneficiaries. At the end of the year 22 contracts will terminate and another 36 will reduce their service areas. All told, about 500,000 beneficiaries or about 9 percent of the current enrollees will lose their current plans. Most of those enrollees will have another Medicare+Choice plan available in their areas, but about 40,000 enrollees will not have another plan and will have to turn to the traditional Medicare program, and another 50,000 would have a private fee-for-service plan as their only Medicare+Choice option.

Speaking of the private fee-for-service option, there have been several recent developments in that arena. Sterling, the one current private fee-for-service plan, has over 20,000 enrollees across their 25 service state area now. However, it has withdrawn from all of Mississippi and from some areas of Texas, which together account for about 13 percent of its current enrollment.

Of particular note, is that Sterling is withdrawing from areas where 20 percent of its enrollment in non-floor counties reside. So in the places where they're in non-floor counties, they're going to be pulling out where a lot of their enrollees are.

A second private fee-for-service plan will enter the program in January. Humana will offer the plan in DuPage County, Illinois, which is an urban floor county that borders Cook County. This year DuPage County is part of Humana's Medicare+Choice Chicago area plan.

From what I understand, this plan will be offered as one of five demos designed to keep plans from leaving. The demos will all incorporate some form of risk sharing between the plans and CMS. The rest of the details are sketchy at this point, but we'll find more.

This table shows the resulting changes in the plan availability for Medicare beneficiaries. Generally speaking, plan availability will drop by a couple of percentage points. For example, in 2002 about 61 percent of Medicare beneficiaries will live in counties with a Medicare+Choice plan compared with 63 percent this year. Not on the table, I also looked at zero premium plans and they will decline from 39 percent of the

beneficiaries having those available down to 30 percent next year.

That's it for the update portion. If there are no questions, I'll push on.

MR. HACKBARTH: Scott, could I just ask a question about the Humana plan? Did I understand you correctly to say that this was being done in conjunction with CMS and it was part of an effort on CMS's part to keep plans involved in the program and they were going to do some risk sharing with the private fee-for-service plan while providing --

DR. HARRISON: That's correct. I believe the plans are one PPO, one private fee-for-service, and three HMO plans.

MS. NEWPORT: We have one, a demo in Pueblo County, Colorado.

MR. HACKBARTH: All right, so the attempt to do risk sharing is not just with private fee-for-service but with various models, including regular HMOs?

MS. NEWPORT: One of the criteria for even doing this was, it was to test alternate payment methods, but you had to be the last plan standing in order to do it. It was a combined effort to keep plans in, but also test under the demonstration authority alternative payment methodologies.

MS. BURKE: Glenn, can I ask Scott or Janet, what are the nature of the demonstration risk-sharing arrangements?

DR. HARRISON: Janet probably knows more than I do, but they seem to be sort of risk corridors and sharing--

MS. NEWPORT: Ours was a risk corridor and we presented the proposed methodology and it was accepted. Don't know what other arrangements are except this one now is a private fee-for-service arrangement. But everything was on the table and was judged and evaluated in the context of what their demonstration authority limitations were. So they had to do a new payment, they couldn't just throw more money onto the table under the formula and have it be a legitimate demonstration of something.

MS. BURKE: Is there something other than simply the risk sharing that is being studied?

MS. NEWPORT: Yes, that's my understanding but again, my caveat would be is I didn't see anyone else's proposal but ours.

MS. BURKE: Murray, it would be interesting over time if they're, in fact, going to put in place this for a year, for us to understand more clearly what are they demonstrating. Whether it's just a question now of what the rates look like and what the corridors look like, or whether there are other issues in the willingness of plans to stay in other than simply rates. Is it just about the rate? Or is it about --

DR. ROWE: My view of it is that there was recognition that the program was underfunded, that the rates were too low, but that there wasn't any way for CMS to increase the rates. So they designed some demonstrations that might have better rates. But the fact is we don't need demonstrations to see whether this program can work. It can work if it's well funded. Janet, what do you think?

MS. NEWPORT: I think that Jack is right. I think that we tried to avail ourselves of the opportunity in order to stay in a

couple of markets. We actually applied for, I think it was six different areas, and this was the only one that met the bounds of their demonstration authority. Frankly, I'm not sure that what we're doing now would work broadly, but only selectively.

I think it reflects a genuine effort on CMS's part to try to do some administrative fixes and be creative around their authority to do some more innovation around ultimately some of the questions Scott asks in his outline, which is what should we do about this?

There's good ideas out there that may not deserve to be explored but they may deserve to be explored.

MR. HACKBARTH: Could I suggest that we hold off on our questions and comments. It's sort of broadening now. Let's get Scott's presentation before us and then we can do our normal round. Scott?

DR. HARRISON: In light of the fact that we keep hearing from Congress that they want help from us in thinking about how to stabilize the Medicare+Choice program, staff is proposing that we focus on options for future direction of Medicare+Choice payment policy and to actually have a discussion of the different options for Congress to see.

With that in mind, we want to start with our view of why we would want to have private plans in Medicare, or what I think our view is why we would want to have plans in the Medicare program.

The number one choice, private plans can offer beneficiaries a choice of delivery systems. All things being equal, more choice is better than less choice. Some beneficiaries may prefer the delivery system and benefit structures of a private plan over those of traditional Medicare fee-for-service program. As example, beneficiaries may value nurse advice lines, low copay structures, or an emphasis on preventive care that is not found in the traditional program.

Quality. Some private plans could possibly provide higher quality care to some beneficiaries than they might receive if they are in the traditional fee-for-service program. Current managed care techniques that might improve quality include care coordination and disease management programs.

Flexibility. Private plans can often be more flexible to experiment with options that might include efficiency that government programs like Medicare would not really have the freedom to pursue. For example, it is politically difficult for government programs to exclude any licensed providers that would accept its terms of participation, and some techniques might require limiting participation to a small group. We've seen how hard it is to get centers of excellence, et cetera, approved.

Extra benefits. The Medicare+Choice program and the risk program before it have clearly been successful in providing extra benefits to some enrollees at no monetary costs to those enrolled. Of course, I should note that in the absence of an adequate risk adjustment system, it's unclear whether the Medicare program has borne a cost for those extra benefits.

Competition. If there were enough private plans participating in Medicare, competition among plans and with the traditional program for enrollment could create incentives for

plans to encourage their providers to learn new more efficient techniques for delivering health care services. If providers then apply these techniques when treating traditional Medicare patients as well the efficiency of the traditional program could also increase. That's sort of the spillover effect.

Now I'd like to move on to lessons that you can draw from the experience of the Medicare+Choice program. Health care markets are local. The variation in spending under the Medicare fee-for-service program is substantial. And the success of the Medicare+Choice program in attracting plans and enrollees very substantially. Private plans can't compete with the traditional program, or at least with the Medicare/Medigap combination, in some areas of the country. But in other areas of the country they can only compete if they were heavily subsidized.

Beneficiaries will make tradeoffs, choosing to give up some choice of provider for extra benefits. Medicare+Choice plans have been very successful in attracting members. Over all areas where Medicare+Choice coordinated plans are offered, about a quarter of Medicare beneficiaries have chosen to enroll. The Medicare+Choice penetration rate is much higher in some areas where plans can enroll 40 to 50 percent of Medicare beneficiaries. The bottom line here is that many Medicare beneficiaries really want these plans.

Private plans should be expected to come and go, however, as they do in commercial, FEHB, Medicaid, and CalPERS markets. Private markets are dynamic and when private plans are used to provide Medicare benefits, we should expect the program not to be static. Beneficiaries are not likely to see the same stability that they expect from the traditional Medicare program.

I'd like to present three general options for the direction of the Medicare+Choice payment policy. One, to establish financial neutrality between the Medicare+Choice plans and the traditional Medicare program. Two, to pay plans more than fee-for-service equivalents in order to attract plans to more areas of the country. And three, to use competitive bidding to find the right rate to pay plans.

The first option reflects recent MedPAC recommendations. Once an adequate risk adjustment system is implemented -- and of course, that still may take a couple of years -- rates should be set at 100 percent of the Medicare fee-for-service per capita spending in the payment area. A specific goal of this option is to encourage plans to offer beneficiaries a choice of delivery systems and benefit packages, so long as there is no additional cost to the Medicare program. Also, by leveling the financial playing fields at the local level between plans and traditional Medicare, the local markets would be allowed to determine what types of plans are successful in each area.

Although this option seems straightforward, there still would be some challenges to overcome. The successful implementation of an appropriate risk adjustment system has been difficult. At this point, CMS has suspended the collection of outpatient and encounter data that they had intended to use in the risk adjustment system because the plans objected it was too costly to collect. CMS is exploring its options, but has yet to

announce a resolution.

The other challenge is to get the political system to accept that some people in the country will have access to extra benefits and others will not. This has not been easy to do, as evidenced by the legislative increases in the floor rates.

Option two is to pay more than the fee-for-service equivalent to attract more plans, especially are to areas that don't currently have any choices. Examples of recent uses of this option have included the floor rates, blended rates, and bonus payments to plans who enter areas where there are no existing plans.

The goals of this option include the expansion of plan choice to more areas and the encouragement for plans to offer higher quality care and/or expanded benefits. One other goal that might be served by this option is to keep plans in the program so that they might be available if the Medicare program were to be reformed.

This option would raise many basic questions. How do we decide how many plans we want and in what areas? How do we decide how much subsidy to provide? How do we target subsidies to get the plan distribution we want? And what tradeoffs do we make between spending more money and having fewer plans?

Option three is to develop a competitive bidding process. You could argue that we have a competitive bidding process now, but it is not now used for setting payment rates to plans. There are many possible formulations for a bidding process, but today I'll just lay out some of the basic goals and issues.

One basic goal is to increase beneficiaries' choice of plans for the same or lower cost for the Medicare program. Another type of goal would be for the competitive market to use price sensitivity to drive value and reduce the cost of health care.

In setting up a competitive bidding process, a whole host of decisions would have to be made. Would the benefit packages be standardized? If so, then the competition would be focused on price, otherwise the competition would be on price and benefits.

How do we deal with the geographic variation across the country? What would the payment areas look like? Would there be national components to the rates? How would we manage the process so that budget constraints are maintained? One of the big questions is what would CMS's role be and how would the traditional Medicare program be included in the process? Would it be a bidder, as well? Is it okay if the traditional program is the only choice in some areas? If not, do we need to recruit national plans? And last, but not least, in making such a change, how would be begin to demonstrate such a program before full implementation, given that we've had trouble with launching demos before?

Thank you.

MS. NEWPORT: Scott, I know you're aware of this -- because we've been around the block on this one before, but there's been comment made to us that instead of about a million folks being affected by exits from the M+C program as has been in the last few years, it's about half of what it was. So that there is a perception that it's slowing. I think that that's the wrong

impression. I think that there's two things that need to be involved in the analysis.

The other thing that Scott probably hasn't been able to measure is the change in the benefit packages, which may have an impact on shrinking the enrollment even further next year. Because the magnitude of change that I've seen in some of our markets is very significant. Increased monthly premiums, shrinking the pharmacy benefit. And I think that I have pushed our folks around a little bit internally to say what do you think that indirect number will be? And I think there's too many variables in terms of who else is left in what market and what the package looks like. And I think that the growth is significantly declining.

The other problem we have is that the expectation for Medicare reform has been postponed. I never thought it would happen this year anyway, but I think that there had been a promise or a hope or whatever somewhat optimistic attitude you might want to take on this, is that plans would have a line of sight to what reform looked like vis-a-vis what their potential participation payment, all of the things that come with that. And now, and we know why, it unfortunately has gone away in terms of a delay in what reform will look like and how we measure that and how much money will be on the table for a drug benefit.

So what we look at now is what I'm calling a bridge to reform. What is going to be there as a placeholder to keep, at worst, a steady state. But that it is very problematical for the plans, in terms of having the vast amount of uncertainty over this.

For the record, PacifiCare exited between 65,000 and 70,000 enrollees, depending on what database you use and the timing of the database with HCFA's data versus ours, and that's a timing issue. But I'm very concerned about what the net effect indirectly on enrollees is.

I've thought about every kind of payment option there is out there, in terms of risk, but I think the competitive bidding option is still clearly on the agenda of Congress, in terms of what they would like to do. Some model off of that. I hear a constant refrain, they're still there. And I think that the focus of the various options in the paper, we need to acknowledge that maybe there's some reordering in your outline, Scott, that I would suggest. It's just that I think we have to look at that. And then obviously look at other options, in terms of what effect it's going to have.

There is this sort of naivete, I think, around investors in our programs confidence that the government is a useful partner. I think that makes it really difficult from some standpoints. In the balance, we have to strike in terms of our participation in the market, and even in the commercial markets, because they're interwoven.

So anyway, Scott, I think you've outlined the issues. I think, at this point, once we see a draft, it will be helpful. But I would want to have a placeholder there about the effect of benefit changes on participation by enrollees. And again, I know you haven't had a chance to do that yet.

We're not even sure exactly what that is. We have surmises. But I think what we do as a Commission, in terms of consistency with our earlier reports, which talks about payment off 100 percent of fee-for-service, and creating a balance between that and what competitive bidding does.

Getting incentives out there so there's new entry and expansion in the program for participants or contractors will have to be reliant upon, I think, our satisfaction if you will that there won't be a lot of huge change every year. We're feeling that every time we turn around there's another set of changes and another set of costs. Some of these are related to other things that are happening, too, including HIPAA.

So I think part of it would say is just fixing payment -- just some basic changes to the payment, but don't change it so drastically that it creates a continued disincentive to new entry. I think the key is how we incentivize new entry and expansion, instead of enrollment decline. But other people will weigh in on the debate as well, I'm sure.

DR. ROWE: Just a couple comments. I think this is very well done. For the record, Aetna was in 49 counties, withdrew from 23 of them, stayed in 26 of them. The criterion I applied was if the average medical cost ratio projected for next year in the county was over 100 percent, we should withdraw, not counting administrative costs. That was the criterion that was used. The average projected 2002 medical cost ratio in those 23 counties was well over 100 percent. So this is not, as some people think, well it's at 78 percent but we really want it to be 74 so we'll withdraw.

I had a couple of comments. With respect to Janet's comment about the benefits buy down, I think there's another factor going on here. I think that while a smaller proportion of plans withdrew or members were withdrawn than everyone expected, that that is misleading because there are a very substantial number of plans poised on the cliff. And I think that as you analyze the data, Scott, if they become available to you, what you will find is that many of the plans, if not all the plans, have increased the supplemental premium to the maximum permitted number. That's what they have done this time in order to try to stay in the county.

So it's not really you're in or you're out. It's you're in with what benefits at what supplemental premium or you're out. And what everyone has done is increase the supplemental premium to the max in order to stay in because people want to stay in the program and serve the beneficiaries. And the next time around, if financial performance continues to deteriorate and there is no place to go, down on the benefits or up on the supplemental premium, I think we will see a very substantial number of people bailing.

So I think that for that component of this chapter, the benefits as well as the supplemental premium issue, should be included. That would be my recommendation.

With respect to the various options, I think that it is true that many people and many elected officials feel that many people love the program and want to stay in the program. But the

question is really do they love the old program with free eyeglasses and pharmaceutical benefits? Or do they love the program that they could get now? I think that that distinction is not sometimes made in calls that I get from elected officials, we have that conversation about well, even if I were to stay in I couldn't offer what they used to have, which is what they remember.

There is a very interesting principle that Bob Reischauer articulated, I think, most clearly for me a couple of years ago, before I was in this side of the health care enterprise. That was that the idea was to provide choice for the Medicare beneficiary at no additional cost to the program. And I ascribe to that and I think that that makes sense. That guided me in my thinking.

You now have an option here, which people are increasingly talking about, about paying more in some way in order to try to make this available and what might the rationale be. One rationale that I have heard, that might be included in whatever you write and you might decide to discard it or support it, is that in fact, in a local market, because of the Medicare market share and the pricing power that they have with physicians and hospitals that, in fact, an individual plan cannot compete at the same payment because it doesn't have the muscularity that Medicare has with respect to its pricing. So that in fact, depending on the market shares, et cetera, there's just no way to get there.

So that is just an idea that some people have espoused and then might go into the mix of things to be considered.

The last thing I would say is really an echo, I think, of what Janet said. On page four, number C of your outline, you do have a section of competitive bidding, which I thought was very interesting and very nicely done. I didn't see that slide. If my having missed that slide does not suggest my inattention, but the fact that it may have fallen off the current version of the outline of the chapter, I would suggest you put it back on and have some discussion about it. Because I don't know if we're going there, people closer to this might know more about whether we're going there. But it's certainly interesting and if there is discussion in Congress about it, then it might be helpful for us to have something to talk about next time. Maybe others here know whether, in fact, it has any legs at all.

Thank you.

MR. HACKBARTH: Does anyone want to respond to that?

MS. RAPHAEL: I just had a question on competitive bidding. I was wondering if you could explain a little more the rationale for people paying a premium for staying in the traditional fee-for-service system?

DR. HARRISON: In the outline I had given you I had presented one potential model for a competitive bidding system. The major motivation behind that particular model was to try to keep things equal across the country, so that all beneficiaries would have access to the same benefit package at the same price.

Because of the variation in fee-for-service what you would have to do is, in some areas of the country, people couldn't get

that package by going through the traditional Medicare program. Because let's say in New York, the traditional Medicare package may cost more than it would cost a managed care plan to provide that same benefit package. So the idea was that you would make the entitlement to the actual benefit package, not to getting traditional Medicare. So in some areas of the country then, perhaps in New York, you'd end up having to pay a premium to get that benefit package if it was delivered through the traditional Medicare program.

MS. RAPHAEL: So would the flip be true?

DR. HARRISON: Yes. So in places where the fee-for-service program were more efficient, you would stay in the traditional Medicare program and you would have to pay if you wanted to go into a managed care product.

DR. REISCHAUER: Just to add on to Carol's question, or the answer to it. When you set up a competitive system you have to have some kind of reference price that you are competing around. Some of these models have it the lowest bidder in a geographic area. President Clinton's policy was ever Medicare fee-for-service costs in the area. The Bipartisan Commission's variant was sort of the average of the bids in an area. And so you can set this thing up anyway you want.

I think most of the political interest, in the short run at least, is in options that would hold people in the fee-for-service system harmless. So they would say to people in the fee-for-service system, if you want to stay in that you don't have to pay anymore than what you're paying now. You choose a more efficient plan that has a cheaper premium and you'll get a rebate or some extra benefits. You choose a less efficient plan, you'll have to pay more on top of that.

An observation on the comments that Jack and Janet had, which I would hope that when we talked about the supplemental premiums we would talk about them in the context of the counterfactual. What's the alternative? And the alternative is Medicare fee-for-service plus Medigap. And what's happening to those payments as well? The salvation of PacifiCare is rapid rise in Medigap premiums, one would hope, and you, too.

Some observations on your material, Scott. One is sort of on the why we have private plans in Medicare. Choice and quality I'll buy. Flexibility, competition and additional benefits at no extra cost, I think, really collapse into two things. One is innovation, which can come out of competition and other things. That's why we're interested in it. The second is saving money, either beneficiaries saving money or the system at large saving money. Competition for competition's sake is sort of like who cares? Or flexibility.

The other observation is I thought you made too much out of changes the norm and private markets and went a little overboard there. In general, you're right and we don't care about entry and exit for gas stations, but consumers do care a lot about continuity when it comes to lots of other services and products they buy. And insurance is a key one.

If your life insurance company was changing, your car insurance company every year, there would be problems. And so I

think you should talk about how in some services continuity is an important component of the quality of the product you're buying, or dimension of the product you're buying.

DR. HARRISON: Right. I thought one of the lessons really should be that if we're going to have private plans, we need to make the transitions easier for the seniors, the beneficiaries.

DR. REISCHAUER: Right. And it's an argument for having relatively high hurdles for who can enter the market, so they aren't sort of fly-by-night people who are here today, gone tomorrow, and they're making commitments and have the ability to stay with it for five years.

DR. BRAUN: I just wanted to remark that I think particularly in the part of the outline where you talk about what lessons can we draw from the Medicare+Choice experience, I think we ought to add one more in, and that's the need to protect the traditional fee-for-service because of the natural instability of the private market. We need to be very sure that traditional fee-for-service is there when other things aren't.

MR. FEEZOR: I wanted to, I think, concur with Janet and Jack's observation that while this year may be a little bit of a slowdown that we've seen, that if California is any harbinger of things to come, it will certainly increase and continue. The pressure will be on further erosions.

Second, I guess I'd like to reinforce Bob's comment, that I think that one of the objectives from a public policy standpoint in the M+C plan or going with choice was, in fact, trying to save money or make some tough decisions that perhaps we, as a society, aren't willing to touch. And yet, from the individual standpoint, clearly the preference -- and again I said a little earlier -- I almost want to do a takeoff on the Clinton campaign. It's the security, stupid. It really is the sense of better value and the certainty that our seniors expect and want to expect, and compared to an absence of that, either in terms of comprehensive coverage or perceived value, that really sets it up.

When CalPERS was struggling, I have a PPO plan that is, I guess, the equivalent of the regular Medicare fee-for-service. It's pricing is getting so disproportionate that it is no longer the choice. It's the only choice that all counties in California that I can provide. It's the only one that's provided nationwide, as well. And it is so extraordinarily expensive that the value that my enrollees perceive in the HMOs compared to my PPO is just so out of proportion, that they are not happy when there is only that single choice left.

But again, it is not choice that's driving it. It is, in fact, the value and the lack of comprehensive coverage.

Janet's right on target. If you look a little more carefully behind the benefit-to-premium ratios for the remaining market, I think as you will see -- and again on Bob's observation -- the pricing of the M+C plans which were largely, I think, underpriced to begin with, as they begin to rise up to meet other alternatives it will be interesting to see if that sort of loyalty remains.

I think there is because of some additional comfort,

security and value that our enrollees feel in many of these plans. But that certainly will be tested.

One other thing, this gets back to the sense of security or certainty in those plans, I think one of the things that's really making it very hard on the Aetna's and the PacifiCare's of the world to stay in is the dramatic fluctuation of the underlying inputs. It's countercyclical to our economy's ability to afford it. And that also translates to our individual enrollee's ability to afford it.

I don't know what attention or energy we can bring to that, but I can tell you the amount of repricing that we have going on from the provider side in California -- perhaps we enjoyed depressing those rates -- maybe now what I can call the variable interest on our mortgage has come due. But having to make it up all in one or two years is absolutely cataclysmic to the market. And I think again, not recognizing the underlying tremendous variations that plans have to encounter to stay in the market to provide that sense of security and permanence that our enrollees demand is something that needs attention.

One thing, Scott -- and by the way, I thought it was an excellent outline of a difficult area -- we talk about rural floor counties versus richer or higher cost counties. Maybe I'm a little too blunt-spoken for Washington, and probably for Sacramento to some degree, but it really is most of the erosions that we see, not just in our Medicare market but in our standard choice market -- under-65 -- is really a non-competitive market. Where in fact the negotiators, whether it's my own PPO or whether it's the Cigna's of the world, simply cannot get the margins they need between -- and when you have Medicare's purchasing power, as I think Jack talked about, is what you have to compete with, that is very unrealistic. But it is largely in what I call, and I think you need to make some reference to it -- it's not just in low cost counties. It may be that a low cost county where providers are willing to, in fact, negotiate or engage in care management, that they will still succeed. But in counties, in fact, where the provider is disinclined either to engage in terms of more realistic pricing or in terms of significant involvement in care management is probably where most of the problem is.

And then finally, down the issue that I do think we need to warn our friends on the Hill about, and I caution us, we talk about the fact -- I think Scott your term, we need to make sure our seniors are able to handle the transition if we, in fact, are stretching a market that has greater entrance and exits. Let me just tell you, having made one in eight or one in nine of my enrollees have to choose and move to a new plan this year in the attempt to save about $135 million or $140 million. My board thought that was a great idea in April. And now in August and September when those complaints, even though we had predicted exactly how many new people would be displaced by this and they said yes, it's good value, it's a good thing to save $135 million or $150 million.

But my board, who in many respects is a representative or a legislative body, had a very different opinion in terms of what value was important. So I do think that we need to warn that if

we are talking about a marketplace or relying on a marketplace where there are greater entrance and exits, again -- particularly for our seniors -- the sense of security -- and if you look at the number of -- each year my 30,000 people until this year I'm putting 150,000 making the change.

Of the 30,000, the smallest percentage who make changes are the seniors. They like to make that choice and get comfortable with that. And so to expect that they will migrate mightily for another $2 here or there, I said they are able to seek out good value. But I think for my senior population there is perhaps a greater threshold that they expect before they will move.

DR. NEWHOUSE: I have two comments. The first is a deja vu all over again comment. For this program to work reasonably well for all the parties who have a stake in it, there is going to have to be tolerably good risk adjustment. Now to the degree -- and Scott recognizes that.

The point I'd like to go on further here is to the degree that this process is inevitably playing out over a longer time period, encounter data collection is on hold, it seems to me that the logical consequence of that is to go to risk sharing or partial capitation and, in fact, have an increased weight on that.

I would actually be interested, not now, in finding out what CMS plans are to evaluate these demos, what questions they're asking and what they hope to learn from that. But leave that aside. That was in here but it wasn't really brought, I thought, sufficiently emphasized in the talk.

The second comment is that, from my point of view, the worst of these options is a subsidy option by far. My concern with it is that if one wants to say that plans aren't going into areas where they don't have much bargaining power, which I think is in fact the case with providers, and there's effectively local monopolies with either or both of hospitals and certain physician specialities, that even with subsidies you're still not going to have any bargaining power. And so the degree you put in subsidies, the subsidies will pass along through to the local providers and the plans will know that. So they still won't go there, so you really haven't accomplished anything in my view, except potentially to up rates to local providers through the plan.

MR. SMITH: Very briefly, Glenn. Joe's last point was the point I wanted to make. I guess the thing that occurred to me, listening to Janet, Jack and Allen -- and Scott you get at this some, but after listening to our colleagues, it seems to me maybe we want to try to emphasize in this section a little bit more of the sense around this table of the illusion of choice. That if what we're having is a regression to the mean and that, with some combination of premium increases, exits and benefit reductions, all we're going to have is a choice about who you pay fee-for-service rates for. But we ought to say that.

The Commission has certainly come to that, or at least expressed that view in several ways. But it's very important, it seems to me, as a predicate to this discussion again that if we think what's happening in this marketplace is what choice was a

proxy for, which was additional benefits, are being eroded then we ought to be clear about that. And if the new data allows us to say that more clearly or describe that trend, we should.

I guess the other thing that I'm struck by is the importance of this conversation for the end of the agenda tomorrow, which is the benefit package discussion. This is ultimately about the benefit package. And even though a lot of the folks who call you, Jack, say what they're interested in is choice, that's not really why senator whoever is calling you. They're interested in protecting a more modern, more aggressive benefit package for constituents who are mad that Aetna is pulling out.

Again, we ought to be clear about that, it seems to me, in this chapter and try to get this discussion focused on the real issue which is the benefit package and our inability it seems in many marketplaces in the country to improve the benefit package with the choice mechanism. And say that more explicitly than I think you have before.

DR. ROWE: If I may add a point here, one way to say what we're all saying, maybe the unit of this analysis should not be the health plan but should be the beneficiary. One way to talk about this is to say this is about the beneficiary. And what, in fact, is it going to cost the beneficiary, traditional Medicare plus Medigap versus what's really out there in the market, supplemental, what is the benefit package, et cetera, et cetera. Rather than the economic analysis of the pricing power of Medicare versus that of the health plan.

That's important, too, and I support that. But at least once slice of this should be trying to look at it through the lens of the beneficiary and what the real choice in the current market is.

MR. HACKBARTH: The point that I keep coming back to, the question that I keep coming back to, is it good policy under some circumstances for the federal government to pay more for a beneficiary that chooses a private health plan option? I've bored people to death saying over and over again that my world view is that we ought to offer a financially neutral choice between the traditional fee-for-service program and private options. I'm trying to open up my mind and think new thoughts here.

There are various ways that we might arrive at that destination, various mechanisms we might use to pay more for a private option than Medicare. I agree with Joe's comment about a subsidy probably being the worst of those. But let's take competitive bidding as an alternative framework that may well arrive at the same result of a higher payment for a private option.

The question I keep coming back to is how is that ultimately any different -- let me just finish Joe, and then you can set me straight.

How is that any different than what we have criticized under the private fee-for-service option, where we see the floors as creating an opportunity for a private plan to come in and basically do nothing, add no value, use the Medicare payment systems even for providers and just benefit by the arbitrary

separation between what they're paid and what the fee-for-service program pays? I just don't see the public policy benefit in that separation.

Okay Joe, what did I say wrong?

DR. NEWHOUSE: I was going to agree with you, but I guess I still have a closed mind on neutrality. I was going to emphasize the flip side, that in the high rate areas we're now paying less and we shouldn't be surprised if we see exits when we do that. This goes back to the all health care markets are local point and the non-neutrality point.

I think both sides of this deserve emphasis.

MR. HACKBARTH: Right. Just to pound on that same point, if we have an artificial cap on what we pay private plans, potentially what we're doing is having plans exit and losing opportunities for Medicare beneficiaries to get more benefits, for there to be more competition simply because of an arbitrary public policy limit.

And on the other side, if we're paying more for the private option, we'd have these opportunities for gaming the system. I just can't find a way out of that box and I keep coming back to neutrality is really the only logical acceptable stance for Medicare on this.

MS. RAPHAEL: These sort of go back around to why you said you want a private plan. It increases choice, quality, flexibility, competition. Now we're questioning choice as to whether or not that's valid. Let's assume it is, then quality, and then innovation.

I think from my point of view if you're going to put in the subsidy, how clear are we on the benefits side of this equation? Certainly in what we've seen here, we don't have much empirical evidence to me. It's a lot of in the future, these private plans might innovate, it might spillover in fact to the other side and have some beneficial effect.

I don't know what you have on the quality side that might be meaningful.

MR. HACKBARTH: In fairness, I guess it boils down to a question of how much are you willing to pay for these benefits that Scott has enumerated? I'm wondering whether we ought to be paying that price just to say you have a private option.

DR. REISCHAUER: I think it's very hard to make a case that just to provide choice, when choice offers nothing else -- it doesn't offer quality, it doesn't offer innovation, it doesn't offer any kind of spillover effect -- is worth paying a penny for. But what your formulation, which is neutrality, says other things being equal, if you don't have to pay anything more for it but we have an opportunity to provide choice, then provide choice.

DR. ROWE: I think the issue is what is it a choice of? Because we can write articles about how managed care offers disease management and utilization management and blah, blah, blah. But the fact is, from the consumer's point of view, it's whether it covers prescription drugs or not.

DR. REISCHAUER: No, but there's something more to it than that. It is that you have a different cost sharing structure in

almost all of these plans than traditional Medicare alone. And that is important for a lot of people. DR. ROWE: I think that's right.

DR. REISCHAUER: So forget about the drugs, forget about the vision care, all that stuff. Just laying out a plan that has no hospital deductible, small hospital copayments, is worth something.

DR. ROWE: That's one analysis from the bene's point of view.

MR. SMITH: It's certainly part of what Janet was saying. What's eroding are those kinds of benefits, whether it's measured in terms of premium increases or copay increases. That does appear to be what's eroding, even when there's not an exit.

DR. NEWHOUSE: I agree with the comments that have been made about the beneficiaries' point of view, but I think there's another reason for this plan, which goes back to how we spend most of our time in this commission, which is worrying about potential or actual distortions that are introduced by the administered pricing schemes in traditional Medicare.

We worried about is the geographic adjustment in the wage index right. We worried about is there going to be substitution of care from home health agencies to SNFs or vice versa because we have two different payment systems or from the outpatient department to ambulatory surgery centers. And we spend hours and says on trying to fine tune what amounts to a national system that inevitably is going to have some misses at the local level, potentially significant misses.

By basically trying to free up the plan below the plan payment to contract with providers in the local community it seems to me we escape a lot of the potential distortions that the administered price system that traditional Medicare inevitably has to use, given its essentially dictum that every provider is going to be in it, has to use. And that's another reason for wanting this that I think hasn't really been brought up here.